

# SEED Follow-Up Health and Development Core Survey

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## A. General Health

1. In general, how would you describe this child's health?

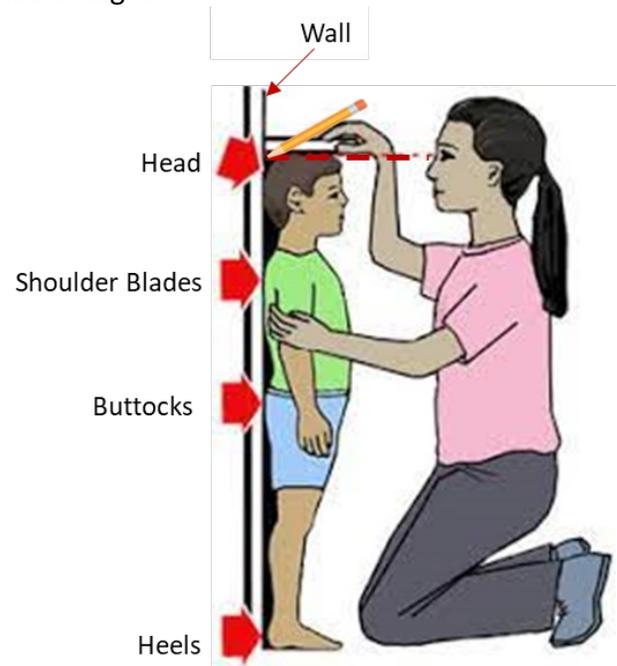
- Excellent
- Very Good
- Good
- Fair
- Poor

## Height and Weight

2. How tall is this child now (without shoes)?

Please follow the instructions below to measure your child's height.

1. Ask child to remove shoes
2. Have child stand against wall
3. Make sure child's head, shoulder blades, buttocks, and heels are touching the wall
4. Place book or flat object on top of child's head
5. Use pencil to mark a line on the wall, below the book
6. After making a pencil mark, child can step away from wall
7. With a measuring tape, measure the height from floor to pencil mark
8. Please record child's height to the nearest quarter inch below



If your child does not agree to be measured, please record the most recent height measure you recall, such as from a past doctor visit.

Click or tap here to enter text. inches (measured with tape measure for this study)

OR

Click or tap here to enter text. inches (recalled height from past measurement, such as doctor visit)

OR

I don't know

3. How much does this child weigh now (without shoes)? Please weigh this child on a scale if possible. If your child does not agree to be weighed; please record the most recent weight you recall.

Click or tap here to enter text. pounds (weighed on scale at home)

OR

Click or tap here to enter text. pounds (recalled weight from past measurement, such as doctor visit)

OR

I don't know

### Dental Health

4. DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following? *Please provide a response for each item listed below. If your child does not have any of the conditions listed below, please select 'No'.*

	Yes	No	Don't Know
Toothaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decayed teeth or cavities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Sleep Health

5. The next set of questions will ask you about your child's typical sleep schedule during the week and on weekends.

SLEEP SCHEDULE ON WEEKDAYS	
What is their typical bedtime on WEEKDAYS? <i>(Sunday night - Thursday night)</i>	Bedtime: ____:____ <input type="checkbox"/> AM/ <input type="checkbox"/> PM
When do they usually wake up on WEEKDAYS? <i>(Monday morning - Friday morning)</i>	Wake-up time: ____:____ <input type="checkbox"/> AM/ <input type="checkbox"/> PM
SLEEP SCHEDULE ON WEEKENDS	
What is their typical bedtime on WEEKENDS? <i>(Friday night and Saturday night)</i>	Bedtime: ____:____ <input type="checkbox"/> AM/ <input type="checkbox"/> PM
When do they usually wake up on WEEKENDS? <i>(Saturday morning and Sunday mornings)</i>	Wake-up time: ____:____ <input type="checkbox"/> AM/ <input type="checkbox"/> PM

6. DURING A TYPICAL WEEK, does this child have FREQUENT or CHRONIC difficulty with any of the following?

	Yes	No	Don't Know
Falling asleep at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping too much (day or night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waking up feeling well rested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unintentionally falling asleep during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring loudly during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop breathing during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is restless and moves a lot during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wets the bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. How confident do you feel in your ability to assess your child's sleep habits and/or sleep problems?
- Not confident at all
  - Slightly confident
  - Fairly confident
  - Completely confident

**Gastrointestinal Health**

8. DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following... *(Please provide a response for each item listed below. If your child does not have any of the conditions listed below, please select 'No'.)*

9. How confident do you feel in your ability to assess your child's gastrointestinal symptoms?

	Yes	No	Don't Know
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gaseousness or bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence (loss of bladder control)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soilage (accidental bowel movements)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Not confident at all
- Slightly confident
- Fairly confident
- Completely confident

## Diagnosed Conditions

10. Next please tell us whether this child has any of the health conditions listed below.

*Please answer question A for all conditions in the table below even if this child does not have any of the conditions. Please answer questions B and C for only the conditions this child ever had.*

### Medical Conditions

		If Question A is YES, please answer Questions B & C	
<b>Question A:</b> Has a doctor or other health care provider ever told you that this child has <b>any of the following medical or genetic conditions?</b>  <i>Please provide a response for each condition listed below. If your child does not have any of the conditions listed below, please select 'No'.</i>		<b>Question B:</b> How old was this child when you were first told he or she had the condition? <i>(Write in 0 if less than 1 year)</i>	<b>Question C:</b> Does this child currently have the condition?
<b>Allergy</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <i>(If yes, check all that apply)</i>		
<input type="checkbox"/> Food allergy		___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Skin allergy or eczema		___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Seasonal allergy or hay fever		___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Drug allergy, specify: _____		___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Other allergy, specify: _____		___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Brain injury, concussion, or head injury	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Celiac disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Crohn's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Cystic fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Diabetes (uses insulin)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Diabetes (does not use insulin)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Epilepsy or seizure disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Fragile X Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

Frequent or severe headaches, including migraine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Heart condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Hypertension or high blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Irritable bowel syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Sickle cell anemia/thalassemia/other hereditary anemias	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Sleep-Wake disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <i>(If yes, check all that apply)</i>		
	<input type="checkbox"/> Sleep Apnea	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Insomnia	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Restless Leg Syndrome	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Narcolepsy	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Other sleep-wake disorder, specify: _____	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Ulcerative colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Other medical or genetic condition, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

Behavioral, Developmental, or Mental Health Conditions

		If Question A is YES, please answer Questions B & C.	
<b>Question A:</b> Has a doctor or other health care provider ever told you that this child has <b>any of the following behavioral, developmental, or mental health conditions?</b>  <i>Please provide a response for each condition listed below. If your child does not have any of the conditions listed below, please select 'No'.</i>		<b>Question B:</b> How old was this child when you were first told he or she had the condition? (Write in 0 if less than 1 year)	<b>Question C:</b> Does this child currently have the condition?
Attention-Deficit/Hyperactivity disorder, combined or hyperactive or inattentive type (ADD or ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Anxiety disorder (This includes generalized anxiety disorder, panic disorder, specific phobia, agoraphobia, selective mutism, or social anxiety disorder)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Autism, Asperger's disorder, pervasive developmental disorder, or autism spectrum disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Bipolar disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Cerebral palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Depressive disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Developmental coordination disorder, or motor delay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Feeding or eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Global developmental delay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Intellectual disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Learning disability, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Obsessive-compulsive disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Oppositional defiant or conduct disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Schizophrenia or other psychotic disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Self-injurious behavior (This includes things like self-hitting, scratching, skin picking, or head banging)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Sensory integration disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

		If Question A is YES, please answer Questions B & C.	
<b>Question A:</b> Has a doctor or other health care provider ever told you that this child has <b>any of the following behavioral, developmental, or mental health conditions?</b>  <i>Please provide a response for each condition listed below. If your child does not have any of the conditions listed below, please select 'No'.</i>		<b>Question B:</b> How old was this child when you were first told he or she had the condition? <i>(Write in 0 if less than 1 year)</i>	<b>Question C:</b> Does this child currently have the condition?
Speech or other language disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Substance-related & addictive disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <i>(If yes, check all that apply)</i>		
	<input type="checkbox"/> Tobacco	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Alcohol	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Opioids (e.g., OxyContin, Vicodin, Morphine, Fentanyl)	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Other substance, specify: _____	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Tourette syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Any other behavioral, developmental, or mental health disorder, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	___ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

## Food Allergies and Dietary Restrictions

11. Do you currently avoid any foods or food ingredients for this child because of a known or suspected food allergy or intolerance? *(Check only one box)*

- Yes, diagnosed food allergy  
 Yes, suspected food allergy  
 Yes, confirmed or suspected food intolerance  
 No **(Skip to question 13)**

12. Which foods or food ingredients do you currently avoid for this child? *(Check all that apply)*

Cow's milk or other dairy products	<input type="checkbox"/>	Wheat, gluten, or wheat starch	<input type="checkbox"/>
Soy milk or other soy food	<input type="checkbox"/>	Other grain or cereal ( e.g., oats, barley)	<input type="checkbox"/>
Eggs or egg products	<input type="checkbox"/>	Fruit or fruit juice	<input type="checkbox"/>
Peanuts, peanut butter, or peanut oil	<input type="checkbox"/>	Vegetables	<input type="checkbox"/>
Other nuts (e.g., almonds, pecans, walnuts)	<input type="checkbox"/>	Artificial colors or flavors	<input type="checkbox"/>
Sesame seeds or sesame seed oil	<input type="checkbox"/>	Sulfites	<input type="checkbox"/>
Fish (e.g., salmon, codfish, tuna)	<input type="checkbox"/>	Other foods or ingredients, specify _____	<input type="checkbox"/>

Crustacean shellfish (e.g., shrimp, crab, lobster)  
Beef, pork, chicken, turkey, or another animal meat

None of these

## Communication Abilities

13. Does this child use verbal communication, such as words or noises, to communicate with people?

- Verbally communicates using words easily
- Verbally communicates using words with a little trouble
- Verbally communicates using words with a lot of trouble
- Verbally communicates with noises
- Does not verbally communicate

14. Does this child communicate with people using any of the following non-verbal methods of communication? *These methods can occur with or without verbal communication.*

	Yes	No
Sign language	<input type="checkbox"/>	<input type="checkbox"/>
Lip reading	<input type="checkbox"/>	<input type="checkbox"/>
Simple hand movements	<input type="checkbox"/>	<input type="checkbox"/>
Facial gestures	<input type="checkbox"/>	<input type="checkbox"/>
Eye contact	<input type="checkbox"/>	<input type="checkbox"/>
Picture board	<input type="checkbox"/>	<input type="checkbox"/>
Electronic device (e.g., uses a tablet, laptop, or smartphone to communicate without talking)	<input type="checkbox"/>	<input type="checkbox"/>

## Level of Support Needed

15. Children and adolescents have different levels of support needs. Overall, how much support does your child need to manage these aspects of life?

	No support	A little support	A lot of support
Understanding and communicating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving and getting around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending to hygiene, dressing, eating, or staying alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interacting with other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic responsibilities, leisure, work, and school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joining in community activities or participating in society	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## B. Service Needs and Utilization

### Health Services

1. Is there a place that this child usually goes when he or she is sick, or you need advice about his or her health?  
 Yes  
 No (**Skip to question 3**)
  
2. If yes, where does this child USUALLY go first? (*Check one box only*)  
 Doctor's Office  
 Hospital Emergency Department  
 Hospital Outpatient Department  
 Clinic or Health Center  
 Retail Store or "minute clinic"  
 School (Nurse's Office, Athletic Trainer's Office, etc.)  
 Some other place, specify: \_\_\_\_\_

3. DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for routine preventative care (such as well-child visits or check-ups) or sick-child care?  
 Yes  
 No (Skip to question 4)

	Question A	Question B	Question C
<b>Type of provider</b>	<b>Number of visits in <u>past 12 months</u></b>  <i>Complete each blank. (Write in 0 if no visits)</i>	<b>If your child received <u>routine preventative care</u>, how much of a problem was it to get service from this type of provider?</b>	<b>If your child received <u>sick-child care</u>, how much of a problem was it to get service from this type of provider?</b>
Dentist or oral health provider	# of visits for <b>routine preventative care</b> : _____  # of visits for <b>sick-child care</b> : _____	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months
Hearing care provider	# of visits for <b>routine preventative care</b> : _____  # of visits for <b>sick-child care</b> : _____	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months
Vision care provider	# of visits for <b>routine preventative care</b> : _____  # of visits for <b>sick-child care</b> : _____	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months
General Physician or Medical care provider	# of visits for <b>routine preventative care</b> : _____  # of visits for <b>sick-child care</b> : _____	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months
Medical specialist care provider, specify: _____	# of visits for <b>routine preventative care</b> : _____ # of visits for <b>sick-child care</b> : _____	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months
Psychologist, psychiatrist, counselor, therapist, or mental health care provider (circle type)	# of visits for <b>routine preventative care</b> : _____ # of visits for <b>sick-child care</b> : _____	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months	<input type="checkbox"/> Not a problem <input type="checkbox"/> Small problem <input type="checkbox"/> Big problem <input type="checkbox"/> Did not receive this type of care in the last 12 months

4. DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency department?  
 No visits  
 1 visit  
 2 or more visits
5. DURING THE PAST 12 MONTHS, how many times was this child hospitalized for any reason?  
 No hospitalizations  
 1 visit  
 2 or more hospitalizations

6. DURING THE PAST 12 MONTHS, was there any time when this child needed healthcare, but it was not received? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.
- Yes
- No (**Skip to question 9**)

7. If yes, which types of care were NOT received? (*Check all that apply*)
- Dental Care
- Hearing Care
- Medical care, routine preventative
- Medical care, sick or urgent care
- Medical care, hospital emergency
- Medical care, specialist
- Mental Health Services
- Vision Care
- Other healthcare needed, specify: \_\_\_\_\_

8. Which of the following contributed to this child not receiving needed healthcare services? “Yes” means it was a factor in not receiving services and “no” means it was not a factor. (*Check one in each row*)

	Yes	No
This child did not have health insurance that covered the services needed	<input type="checkbox"/>	<input type="checkbox"/>
This child was not eligible for the services	<input type="checkbox"/>	<input type="checkbox"/>
The services this child needed were not available in this child's area	<input type="checkbox"/>	<input type="checkbox"/>
There were problems getting an appointment when this child needed one	<input type="checkbox"/>	<input type="checkbox"/>
There were problems with getting transportation or childcare	<input type="checkbox"/>	<input type="checkbox"/>
The (clinic/doctor's) office wasn't open when this child needed care	<input type="checkbox"/>	<input type="checkbox"/>
There were issues related to cost	<input type="checkbox"/>	<input type="checkbox"/>
There were issues related to COVID-19 (e.g., concerned about being around others at doctor's office who may have been exposed to COVID-19)	<input type="checkbox"/>	<input type="checkbox"/>
The child's behaviors limited ability to attend or complete a visit	<input type="checkbox"/>	<input type="checkbox"/>
Other reasons, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

### Experience with Child's Health Care Providers

9. Do you have one or more persons you think of as this child's personal doctor or nurse? A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant.
- Yes, one person
- Yes, more than one person
- No

Answer the following questions only if this child had a health care visit IN THE PAST 12 MONTHS. If this child has NOT had a health care visit in the past 12 months, **skip to question 17 in this section**.

10. DURING THE PAST 12 MONTHS, how often did this child’s doctors or other health care providers:

	Never	Sometimes	Usually	Always	Don't know
Spend enough time with this child?	<input type="checkbox"/>				
Listen carefully to you?	<input type="checkbox"/>				
Show sensitivity to your family's values and customs?	<input type="checkbox"/>				
Provide the specific information you needed concerning this child’s health?	<input type="checkbox"/>				
Help you feel like a partner in this child’s care?	<input type="checkbox"/>				

11. DURING THE PAST 12 MONTHS, were any decisions needed about this child’s health care services or treatment, such as whether to start or stop a prescription or therapy services, get a referral to a specialist, or have a medical procedure?

- Yes
- No **(Skip to question 13)**

12. DURING THE PAST 12 MONTHS, how often did this child’s doctors or other healthcare providers:  
(Check one in each row)

	Never	Sometimes	Usually	Always	Don't Know
Discuss with you the range of options to consider for his or her health care or treatment?	<input type="checkbox"/>				
Make it easy for you to raise concerns or disagree with recommendations for this child’s health care?	<input type="checkbox"/>				
Work with you to decide together which health care and treatment choices would be best for this child?	<input type="checkbox"/>				

13. Does anyone help you arrange or coordinate this child’s care among the different doctors or services that this child uses?

- Yes
- No
- Did not see more than one health care provider in past 12 months **(Skip to question 15)**

14. DURING THE PAST 12 MONTHS, have you felt that you could have used extra help arranging or coordinating this child’s care among the different health care providers or services?

- Yes
- No

15. DURING THE PAST 12 MONTHS, did this child’s health care provider communicate with this child’s school, childcare provider, or special education program?

- Yes
- No **(Skip to question 17)**

Did not need health care provider to communicate with these providers (**Skip to question 17**)

16. If yes, overall, how satisfied are you with the health care provider's communication with the school, childcare provider, or special education program?

Very satisfied

Somewhat satisfied

Somewhat dissatisfied

Very dissatisfied

## Health Insurance

17. Is your child currently covered by ANY kind of health insurance or health coverage plan?

Yes

No (**Skip to question 20**)

18. If yes, please tell us which types of health insurance plans your child is CURRENTLY covered under.

	Yes	No
a. Insurance through a current or former employer or union	<input type="checkbox"/>	<input type="checkbox"/>
b. Insurance purchased directly from an insurance company	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicaid, Medical Assistance, or any kind of government-assistance plan	<input type="checkbox"/>	<input type="checkbox"/>
d. TRICARE or other military health care	<input type="checkbox"/>	<input type="checkbox"/>
e. Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other type of health insurance or health coverage plan, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

19. Thinking specifically about your child’s mental or behavioral health needs, how often does this child’s health insurance offer benefits or cover services that meet these needs?

- Always
- Usually
- Sometimes
- Never
- This child does not use mental or behavioral health services

**Education Services**

20. DURING THE PAST 12 MONTHS, has this child attended school?

- Yes (**Skip to question 22**)
- No

21. If no, is this child not in school now because they... (**Check one then skip to question 28**)

- Graduated with regular high school diploma (e.g., the standard high school diploma awarded to students after completing standard high school curriculum & exit exams)
- Graduated with certificate of completion (e.g., certificate or alternative diploma awarded to high school students in special education)
- Took a test for a diploma without taking all of their high school classes (e.g., GED)
- Dropped out or stopped going
- Was suspended
- Was expelled
- Is older than the school age limit
- Some other reason, specify: \_\_\_\_\_

22. If yes, which of the following best describes the school this child currently attends (or most recently attended)? *If this child currently attends 2 schools, describe the school where he or she spends the most time. If this child only attends a school that offers instruction on a specific topic rather than general education check "Other school, specify."*

- A regular public school that serves a wide variety of students
- A regular private school that serves a wide variety of students
- A school that serves only children with disabilities
- A charter school or alternative school
- An online school
- Home instruction by a professional
- Home schooling by a parent
- A vocational/technical school (voc-tech)
- 2-year community college
- 4-year college or university
- Medical or mental health facility, convalescent hospital, institution for people with disabilities, correctional or juvenile justice facility
- Other school, specify: \_\_\_\_\_

23. Which of the following best describes this child's classroom setting?

- Regular classroom with a wide variety of students (this includes both in-person and remote/virtual classrooms). *If Regular (typical) classroom, please specify type below:*
  - Regular (typical) classroom with classroom support (for example, pull out or in class; one-to-one (1-to-1) aide; Collaborative Team Teaching (CTT) or Integrated Co-teaching (ICT) classroom)
  - Regularly (typical) classroom without support
- Special education classroom for students with disabilities or special needs
- Mix of regular and special education classrooms
- Does not apply because this child is home-schooled or not attending school

24. What grade is this child currently in? (If summer, what is the highest grade level this child has already completed)?

<input type="checkbox"/> Pre-school	<input type="checkbox"/> 10 <sup>th</sup> grade
<input type="checkbox"/> Kindergarten	<input type="checkbox"/> 11 <sup>th</sup> grade
<input type="checkbox"/> 1 <sup>st</sup> grade	<input type="checkbox"/> 12 <sup>th</sup> grade
<input type="checkbox"/> 2 <sup>nd</sup> grade	<input type="checkbox"/> College Freshman
<input type="checkbox"/> 3 <sup>rd</sup> grade	<input type="checkbox"/> College Sophomore
<input type="checkbox"/> 4 <sup>th</sup> grade	<input type="checkbox"/> College Junior
<input type="checkbox"/> 5 <sup>th</sup> grade	<input type="checkbox"/> College Senior
<input type="checkbox"/> 6 <sup>th</sup> grade	<input type="checkbox"/> Does not apply, my child did not attend a typical public or private school
<input type="checkbox"/> 7 <sup>th</sup> grade	<input type="checkbox"/> Don't know
<input type="checkbox"/> 8 <sup>th</sup> grade	<input type="checkbox"/> Other education, specify: _____
<input type="checkbox"/> 9 <sup>th</sup> grade	(e.g., 18-21-year-old program for eligible high school students)

25. DURING THE PAST 12 MONTHS, about how many days did this child miss school because of illness or injury?

- No missed school days

- 1-3 days
- 4-6 days
- 7-10 days
- 11 or more days

26. DURING THE PAST 12 MONTHS, how many times has this child's school contacted you or another adult in your household about any problems he or she is having with school?

- No calls
- 1 time
- 2 or more times

27. DURING THE PAST 12 MONTHS, how many times has this child been suspended or expelled from school?

- None
- 1 time
- 2 or more times

28. Since starting kindergarten, has this child repeated any grades?

- Yes
- No

29. Has this child ever changed schools or educational setting because his or her education needs were not being met?

- Yes
- No

30. Have you ever been involved in mediation, a due process hearing, or litigation concerning the child's education services?

- Yes
- No

31. Has this child EVER received special education or an Individualized Education Plan (IEP), 504 plan, tutoring, classroom aide, reader/interpreter, communication device, enrichment program, pull-out program, or accelerated curriculum??

- Yes
- No, my child has never had a plan or services for special education (**Skip to question 34**)

32. If yes, please indicate below which of the following plans or services your child has received.

<b>Question A:</b> Has your child ever received one of these plans or services? <i>Please provide a response for each plan or service listed below. If your child did not receive a plan or service listed below, please select 'No'</i>		<b>If YES to Question A, please answer Questions B &amp; C</b>	
		<b>Question B:</b> If <b>yes</b> , at what age in years did your child first receive the plan or service? (Write in 0 if less than 1 year)	<b>Question C:</b> Does the child currently have this plan or received this service IN THE PAST 12 MONTHS?
Individualized Education Plan or IEP (used for special education services in children 3 or older)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No
504 Plan (sometimes used for special education services instead of or in addition to an IEP)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gifted and talented services, such as enrichment, pull-out program, or accelerated curriculum	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tutoring	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Classroom aide	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reader/interpreter	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communication device or other electronic device (e.g., tablet, laptop, smartphone) to assist with classwork or to communicate without talking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other plan or service, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____ Years	<input type="checkbox"/> Yes <input type="checkbox"/> No

33. Overall, how satisfied are you with the educational plans or services your child has received?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

## Developmental Services

34. Please tell us whether this child has ever used any of the developmental services or supports listed below. These types of services might be received through the school, a healthcare provider, or some other person or place such as an independent therapist.

Please answer question **A** for all services and supports in the table below, even if the child does not use the service or support. Please answer questions **B, C, and D** for only services and supports the child ever received.

		If Question A is YES, please answer Questions B to D.		
		If yes, has this child received the service or support DURING THE PAST 12 MONTHS?		
Question A: Has this child EVER received ...		Question B: If yes, at what age in years did your child first receive this service? (Write in 0 if less than 1 year)	Question C: Received THROUGH SCHOOL DURING PAST 12 MONTHS?	Question D: Received OUTSIDE OF SCHOOL DURING PAST 12 MONTHS?
Audiology or hearing services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Behavioral therapy, such as applied behavior analysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Occupational therapy or sensory therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Physical therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Psychological or mental health services or counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Social skills therapy or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Speech or language therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Other services? Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	_____Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

35. Overall, how satisfied are you with the developmental services or supports your child has received?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied
- My child did not receive any developmental services or supports

## Medications

36. Please tell us whether this child has taken medication because of the difficulties noted below. The medication can be prescription or over the counter.

*Please answer question A for all conditions that may be treated with medication, even if the child does not take medication. Please answer questions B and C for only those conditions that are treated with medication.*

<b>Question A:</b> DURING THE PAST 12 MONTHS, has this child taken any medication because of difficulties noted below at least once per month for at least 3 months?		<b>Question B:</b> If yes to Question A, did the child take a medication prescribed by a doctor or other healthcare provider?	<b>Question C:</b> If yes to Question A, did the child take an over-the-counter medication?
Aggression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Attention, concentration, or hyperactivity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Gastrointestinal problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Repetitive behaviors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Restricted interests	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Obsessive Compulsive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Self-injurious behaviors (This includes things like self-hitting, scratching, skin picking, or head banging)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Sleep problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

## Complementary and Alternative Treatments

37. DURING THE PAST 12 MONTHS, did your child use any type of complementary or alternative health care or treatment to help improve or manage their behavior or development? This could be acupuncture, animal therapy, art or music therapy, relaxation or mindfulness therapy, special diets or supplements, or other alternative treatments.

Yes

No (Skip to question 1 in Section C)

38. If yes, please select all below that apply. Where relevant, please include these regardless of how it was given (e.g., pill, spray, cream, injection, etc.)

Acupuncture

- Animal therapy
- Arts therapy (includes music, art, dance, or drama/acting therapy)
- Auditory integration
- Chiropractic care
- Wellness or Mindfulness (includes massage therapy, relaxation therapy, meditation, and yoga)
- Vitamin or mineral supplements (includes supplements of any vitamin, folic acid, omega-3 FA and fish oils, and multi-vitamin and/or multi-mineral)
- CBD/cannabis (e.g., CBD oil, marijuana, hash, weed, THC edibles)
- Melatonin
- Oxytocin
- Special diet such as gluten-free casein-free (GFCCF), gluten-free only, casein-free only, Feingold diet, ketogenic diet)
- Other complementary or alternative health care or treatment, specify: \_\_\_\_\_

## C. Community and Social Participation

1. DURING THE PAST 12 MONTHS, did this child participate in:  
(Check one in each row)

	Yes	No
Any sports team or sports lessons after school or on weekends?	<input type="checkbox"/>	<input type="checkbox"/>
Any clubs or organizations after school or on weekends?	<input type="checkbox"/>	<input type="checkbox"/>
Any other organized activities or lessons, such as music, dance, language, or other arts after school or on weekends?	<input type="checkbox"/>	<input type="checkbox"/>
Any type of community service or volunteer work at school, church, or in the community?	<input type="checkbox"/>	<input type="checkbox"/>
Any work, including regular jobs as well as babysitting, cutting grass, or other occasional work?	<input type="checkbox"/>	<input type="checkbox"/>

2. DURING THE PAST 2 WEEKS, did this child:  
(Check one in each row)

	Yes	No
Get together socially with friends or neighbors?	<input type="checkbox"/>	<input type="checkbox"/>
Talk with friends or neighbors on the telephone, video conferencing system, or social media APP (e.g., Snapchat, Facebook, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Get together with ANY relatives not including those who live with you?	<input type="checkbox"/>	<input type="checkbox"/>
Go to church, temple, or another place of worship for services or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Go to a show or movie, sports events, club meeting, after school class or other group event?	<input type="checkbox"/>	<input type="checkbox"/>
Go out to eat at a restaurant?	<input type="checkbox"/>	<input type="checkbox"/>

3. DURING THE PAST WEEK, on how many days was this child physically active for at least 60 minutes per day? Add all the time that he or she spent in any kind of physical activity that increased his or her heart rate and made him or her breathe hard some of the time.

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- Every day
- I don't know

4. ON AN AVERAGE WEEKDAY, about how much time does this child usually spend watching TV programs or movies, including streaming services such as Netflix, Hulu, Disney+, Apple TV, etc.?

- None
- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours

I don't know

5. ON AN AVERAGE WEEKDAY, about how much time does this child usually spend playing on an electronic device? *This does NOT include doing schoolwork, or watching TV shows, movies, or videos on YouTube/TikTok.*

None

Less than 1 hour

1 hour

2 hours

3 hours

4 or more hours

I don't know

## D. Bullying and Discrimination

1. DURING THE PAST 12 MONTHS, has this child faced a barrier to community or social participation because of:

	Yes	No
A physical environment that is not accessible?	<input type="checkbox"/>	<input type="checkbox"/>
Lack of assistive or adaptive technology?	<input type="checkbox"/>	<input type="checkbox"/>
Negative attitudes towards people with disability?	<input type="checkbox"/>	<input type="checkbox"/>
A service, system, or policy that prevents equal participation for everyone?	<input type="checkbox"/>	<input type="checkbox"/>

2. Discrimination occurs when people are unfairly treated because they are perceived as different from others. Disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.

Has this child been discriminated against because of a disability?

- Yes
- No, my child has not been discriminated against because a disability **(Skip to question 4)**
- Not applicable, my child does not have a disability **(Skip to question 4)**
- I don't know **(Skip to question 4)**

3. If so, who discriminated against this child (*check all that apply*)?

- Employer
- Educator
- Healthcare provider
- Community worker (e.g., staff in shops)
- Other person or people, specify: \_\_\_\_\_

4. DURING THE PAST MONTH (30 days), how often has this child been bullied by someone else?

- Never **(Skip to question 6)**
- 1 time
- 2-3 times
- 4 or more times
- Don't know **(Skip to question 6)**

5. Please check all the ways this child has been bullied.

	Yes	If yes, check if the behavior occurred in the last 30 days	No	Don't Know
Called bad names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatened that they would be hurt or hit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teased, picked on, or made fun of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed or shoved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hit, slapped or kicked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was electronically bullied or experienced cyber-bullying (this includes being bullied through texting, Instagram, Facebook, or other social media)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ignored or left out of things on purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone tried to keep others from liking them by	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

saying something bad or mean about them, or spreading rumors or lies				
Others stole their things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other types of bullying, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. DURING THE PAST MONTH (30 days), how often has this child bullied another child?

- Never (**Skip to question 1 in Section E**)
- 1 time
- 2-3 times
- 4 or more times
- Don't know (**Skip to question 1 in Section E**)

7. In what ways has this child bullied others?

Please check all the ways that this **child bullied others**.

	Yes	If yes, check if the behavior occurred in the last 12 months.	No	Don't Know
Called someone bad names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatened to hurt or hit someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teased, picked on, or made fun of someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed or shoved someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hit, slapped or kicked someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaged in electronic or cyber-bullying (this includes being bullied through texting, Instagram, Facebook, or other social media)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ignored someone or left them out of things on purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to keep others from liking someone by saying mean things about them, or spread rumors or lies about someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stole others' things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other types of bullying, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. Child Safety

1. Some children are likely to wander off and become so lost that it is necessary to search for them.

DURING THE PAST 12 MONTHS, has this child wandered off or became lost from any of these places, even if it occurred just once. (Check one in each row)

	Yes	No
Your home?	<input type="checkbox"/>	<input type="checkbox"/>
Someone else's home such as a relative, friend, neighbor, or babysitter?	<input type="checkbox"/>	<input type="checkbox"/>
School, day care, or summer camp?	<input type="checkbox"/>	<input type="checkbox"/>
A store, restaurant, playground, campsite, or any other public place?	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you currently have any of the following to specifically prevent this child from wandering off or to find them if they become lost? (Check one in each row)

	Yes	No
Fences or gates to your home or property (e.g., pool gate)	<input type="checkbox"/>	<input type="checkbox"/>
Locks, alarms, or cameras to your home or property (e.g., motion detectors)	<input type="checkbox"/>	<input type="checkbox"/>
Other barriers to your home or property (e.g., window guards)	<input type="checkbox"/>	<input type="checkbox"/>
A tracking device on this child's accessories, body, or clothing	<input type="checkbox"/>	<input type="checkbox"/>
An APP, feature, or tracking device on this child's cell phone	<input type="checkbox"/>	<input type="checkbox"/>

3. DURING THE PAST 12 MONTHS, has this child had contact with a law enforcement officer for any reason?  
 Yes  
 No **(Skip to question 6)**  
 I Don't Know **(Skip to question 6)**
4. Did the officer sufficiently explain his or her actions or procedures?  
 Yes  
 No
5. Are you satisfied with your child's interaction(s) with your law enforcement agency?  
 Yes  
 No

The next question is about events that may have happened during this child's life. These things can happen to any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.

6. To the best of your knowledge, has this child ever experienced any of the following?

	Yes	No
Parent/guardian divorced or separated	<input type="checkbox"/>	<input type="checkbox"/>
Parent/guardian died	<input type="checkbox"/>	<input type="checkbox"/>
Parent/guardian served time in jail	<input type="checkbox"/>	<input type="checkbox"/>
Was a victim of violence or witnessed violence in their neighborhood	<input type="checkbox"/>	<input type="checkbox"/>
Lived with anyone who was mentally ill, suicidal, or severely depressed	<input type="checkbox"/>	<input type="checkbox"/>
Lived with anyone who had a problem with alcohol or drugs	<input type="checkbox"/>	<input type="checkbox"/>
Treated or judged unfairly because of their race or ethnic group	<input type="checkbox"/>	<input type="checkbox"/>
Treated or judged unfairly because of their sexual orientation	<input type="checkbox"/>	<input type="checkbox"/>

## F. You and Your Family

*The next questions are about you and your family*

1. How are you related to this child?

- Biological or adoptive mother
- Biological or adoptive father
- Stepparent
- Grandparent
- Aunt or uncle
- Other relative
- Other non-relative, specify: \_\_\_\_\_

2. What is your age?

\_\_\_\_\_ (Print numbers)

3. What is the highest grade or year of school you have completed?

- 8th grade or less
- 9<sup>th</sup>-12<sup>th</sup> grade; No diploma
- High school graduate or GED completed
- Completed a vocational, trade, or business school program
- Some college credit, but no degree
- Associate Degree (e.g., AA, AS)
- Bachelor's Degree (e.g., BA, BS, AB)
- Master's Degree (e.g., MA, MS, MSW, MBA)
- Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, JD)

4. Are you currently...?

*If more than one, select the one category which best describes you.*

- Employed for wages
- Self-employed
- Out of work for less than 1 year
- Out of work for 1 year or more
- A homemaker
- A student
- Retired
- Unable to work

5. Are you now married, living with a partner together as an unmarried couple, or neither?

- Married
- Living with a partner together as unmarried couple
- Neither **(Skip to question 8)**
- Prefer not to answer **(Skip to question 8)**

6. What is the highest grade or year of school your spouse or partner has completed?

- 8<sup>th</sup> grade or less
- 9<sup>th</sup>-12<sup>th</sup> grade; No diploma
- High school graduate or GED completed
- Completed a vocational, trade, or business school program
- Some college credit, but no degree
- Associate Degree (e.g., AA, AS)
- Bachelor's Degree (e.g., BA, BS, AB)
- Master's Degree (e.g., MA, MS, MSW, MBA)
- Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, JD)

7. Is your spouse or partner currently...?

*If more than one, select the one category which best describes your spouse or partner.*

- Employed for wages
- Self-employed
- Out of work for less than 1 year
- Out of work for 1 year or more
- A homemaker
- A student
- Retired
- Unable to work

## Your Health

The following questions are about your health.

8. In general, what is your physical health status?

- Excellent
- Very Good
- Good
- Fair
- Poor

9. DURING THE PAST 2 WEEKS, for about how many days have you felt very healthy and full of energy?
- Nearly every day
  - More than half the days
  - Few days
  - No days

10. In general, what is your mental or emotional health status?
- Excellent
  - Very Good
  - Good
  - Fair
  - Poor

11. Has a doctor or other healthcare provider EVER told you that you had any of the following?

12.	Yes	No
Attention deficit disorder or Attention deficit hyperactivity disorder (ADD or ADHD)?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety disorder? <i>(This includes generalized anxiety disorder, panic disorder, specific phobia, agoraphobia, selective mutism, or social anxiety disorder)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive compulsive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Autism, Asperger's, pervasive developmental disorder, or autism spectrum disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Depression? <i>(This includes Major Depressive Disorder, Disruptive Mood Regulation Disorder, Dysthymia, and Premenstrual dysphoric disorder)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or other psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Other developmental or mental health condition, specify _____	<input type="checkbox"/>	<input type="checkbox"/>

How well do you feel that you are

coping with the day-to-day demands of raising this child?

- Very well
- Somewhat well
- Not very well
- Not very well at all

13. DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising this child?

- Yes
- No **(Skip to question 15)**

14. If yes, did you receive emotional support from *(check all that apply)*:

	Yes	No
Spouse?	<input type="checkbox"/>	<input type="checkbox"/>
Other family member or close friend?	<input type="checkbox"/>	<input type="checkbox"/>

Health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
Place of worship or religious leader?	<input type="checkbox"/>	<input type="checkbox"/>
Support or advocacy group related to specific health condition?	<input type="checkbox"/>	<input type="checkbox"/>
Peer support group?	<input type="checkbox"/>	<input type="checkbox"/>
Counselor or other mental health professional?	<input type="checkbox"/>	<input type="checkbox"/>
Other person, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

15. DURING THE PAST 12 MONTHS, have you:

	Yes	No
Delayed getting health care or dental care for yourself because of the time needed to care for this child?	<input type="checkbox"/>	<input type="checkbox"/>
Gotten less physical activity than you wanted because of the time needed to care for this child?	<input type="checkbox"/>	<input type="checkbox"/>
Limited your social life because of the time needed to care for this child?	<input type="checkbox"/>	<input type="checkbox"/>

16. DURING THE PAST 12 MONTHS, have you needed help with any of the following as a result of parenting this child?

	Yes	No	Have you or
17. Finding more time for yourself?	<input type="checkbox"/>	<input type="checkbox"/>	
Helping your spouse accept any condition your child might have?	<input type="checkbox"/>	<input type="checkbox"/>	
Helping your family discuss problems and reach solutions?	<input type="checkbox"/>	<input type="checkbox"/>	
Deciding on and doing recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	
Paying for household expenses, such as food, housing, medical care, clothing, or transportation?	<input type="checkbox"/>	<input type="checkbox"/>	
Getting any special equipment your child needs?	<input type="checkbox"/>	<input type="checkbox"/>	
Paying for therapy, day care, or other services your child needs?	<input type="checkbox"/>	<input type="checkbox"/>	
Job counseling or help in getting a job?	<input type="checkbox"/>	<input type="checkbox"/>	

other family members living in your household EVER stopped working or cut down on the hours you work because of this child's health or health conditions?

- Yes
- No

18. Have you or other family members living in your household EVER avoided changing jobs because of concerns about maintaining health insurance for this child?

- Yes
- No

19. As a result of parenting this child, do you feel:

	Yes	No
That this child is much harder to care for than most children his or her age?	<input type="checkbox"/>	<input type="checkbox"/>
That this child does things that bother you a lot?	<input type="checkbox"/>	<input type="checkbox"/>
Angry with this child?	<input type="checkbox"/>	<input type="checkbox"/>
An increased sense of personal strength and confidence?	<input type="checkbox"/>	<input type="checkbox"/>
That your priorities have changed?	<input type="checkbox"/>	<input type="checkbox"/>
A greater appreciation of life?	<input type="checkbox"/>	<input type="checkbox"/>
Pleasure in the child's accomplishments?	<input type="checkbox"/>	<input type="checkbox"/>
Increased faith/spirituality?	<input type="checkbox"/>	<input type="checkbox"/>
That you have more meaningful relationships?	<input type="checkbox"/>	<input type="checkbox"/>
The child has had a positive effect on the wider community?	<input type="checkbox"/>	<input type="checkbox"/>

## G. Household Information

1. Is this child of Hispanic, Latino, or Spanish origin? (Check one)

- No, not Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin

2. What is this child's race? (Check all that apply)

<input type="checkbox"/> White	<input type="checkbox"/> Korean
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> Chinese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan
<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander

3. How many **other** children under the age of 18 years are now living in the household? **Not including this child.**

Number of children \_\_\_\_\_ (If 0, skip to question 5)

4. Do any of these children have any disability, developmental delay, special need, or condition?

- Yes
- No

5. How many adults 18 years or older are now living in the household? **Not including this child.**

Number of adults \_\_\_\_\_

6. How many of these adults in your household are family members? *Family is defined as anyone related to this child by blood, marriage, adoption, or through foster care.*

Number of people \_\_\_\_\_

The next questions are about your total income in the last calendar year before taxes.

Income is important in analyzing the health information we collect. For example, with this information, we can learn whether people in one income group use certain types of medical services more or less often than those

in another group. Please be assured that, like all other information you have provided, these answers will be kept strictly private.

7. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What was your yearly total household income before taxes? *Include your income, your spouse's or partner's income, and any other income you may have received.*

\$  ,  ,

TOTAL AMOUNT  
In the last calendar year

If you are unable to provide a specific amount, please indicate an estimated range of total yearly income below.

- \$0 to \$16,000
- \$16,001 to \$20,000
- \$20,001 to \$24,000
- \$24,001 to \$28,000
- \$28,001 to \$32,000
- \$32,001 to \$40,000
- \$40,001 to \$48,000
- \$48,001 to \$57,000
- \$57,001 to \$60,000
- \$60,001 to \$73,000
- \$73,001 to \$85,000
- \$85,001 or more

8. DURING THE LAST CALENDAR YEAR, how many people, including yourself and this child, depended on this income?

Number of people \_\_\_\_\_

## H. Individual Strengths

*The following questions ask about characteristics and abilities you view as individual strengths of your child.*

1. Would you say the following are individual strengths of this child?

	Yes	No
Courage	<input type="checkbox"/>	<input type="checkbox"/>
Empathy	<input type="checkbox"/>	<input type="checkbox"/>
Forgiveness	<input type="checkbox"/>	<input type="checkbox"/>
Kindness	<input type="checkbox"/>	<input type="checkbox"/>
Gratitude	<input type="checkbox"/>	<input type="checkbox"/>
Humor	<input type="checkbox"/>	<input type="checkbox"/>
Optimism	<input type="checkbox"/>	<input type="checkbox"/>
Resilience	<input type="checkbox"/>	<input type="checkbox"/>
Self-control	<input type="checkbox"/>	<input type="checkbox"/>
Self-efficacy, or belief he or she can be successful	<input type="checkbox"/>	<input type="checkbox"/>

2. Please describe the best things about your child below.